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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/03/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 2 level spinal fusion with 1 day LOS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that medical necessity has not been established for the requested 2 level spinal fusion with 1 day LOS at this time

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old male who was injured on xx/xx/xx while picking up a. The patient was initially followed for complaints of low back pain radiating to the lower extremities with associated numbness and tingling. The patient had prior laminotomy at L4-5 with implantation of spinal cord stimulator. The clinical records noted infection that developed at the spinal cord stimulator site which was treated with antibiotics. The patient was recommended to have a spinal cord stimulator removed in June of 2014. Following the removal of the spinal cord stimulator the patient continued to describe low back pain radiating to the lower extremities left side worse than right with associated burning and tingling. Physical examination from 08/07/14 noted limited strength in the ankle and toes in dorsiflexion. An updated MRI was recommended and done on 11/06/14 noting disc desiccation and disc bulge at L3-4 resulting in mild to moderate central canal stenosis with annular tearing involving the inferior aspect of the annulus. Neural foramen appeared patent at this visit. At L4-5 there was annular tear with disc bulging resulting in minimal central canal stenosis. No neural foraminal stenosis was evident. There was some fluid evident in the facet joints. Radiographs of the lumbar spine from 01/07/15 found no evidence of instability.
The patient was seen on 11/13/14 with no change in symptoms. opined the MRI showed severe disc space degeneration at L3-4 and L4-5 with annular tearing. The patient had not improved overall with traction or aquatic therapy on a long term basis. Recommendations were for lumbar interbody fusion from L3 through L5. The patient had recent ER visit on 02/09/15 for complaints of severe low back pain. Evaluation found no evidence of neurological deficit. CT of the lumbar spine noted disc extrusion at L3-4 resulting in moderate canal stenosis with canal measuring 37.3mm. Post-operative changes at L4 were evident. The requested two level lumbar spine fusion from L3 through L5 with one day length of stay was denied by utilization review as the opined disc space collapse and spondylolisthesis reported was not corroborated by imaging studies. The most recent denial

on 01/12/15 indicated that images of the studies were provided for review and reported to have maintained disc spaces with no evidence of spondylolisthesis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation submitted for review establishes that the patient has persistent complaints of low back pain radiating to the lower extremities. The patient recently required an ER visit due to severe pain with updated CT studies showing disc extrusion at L3-4 contributing to moderate central canal stenosis. The most recent CT noted lack of evidence of spondylolisthesis or any evidence of instability. There was no indication of any substantial disc space collapse at L3-4 or L4-5. The most recent CT would support further surgical considerations at L3-4 due to size of disc herniation and amount of stenosis; however, no further findings at L4-5 were evident to support a two level fusion as requested. The concerns of the prior reviewer regarding lack of consistent findings on imaging studies has not been addressed. Given that the prior reviewer had actual images of the most recent MRI available for review which were reported to show no evidence of disc space collapse or spondylolisthesis, the clinical documentation submitted for review has not established that the proposed procedures would be medically appropriate. It should be noted that this reviewer did not have access to the actual images of recent diagnostic studies. As such it is the opinion of this reviewer that medical necessity has not been established for the requested 2 level spinal fusion with 1 day LOS at this time and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)